Arizona Dept. of Health Services Division of Behavioral Health Services

Encounter Tidbits

Arizona Department of Health Services

June 2005

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www.azdhs.gov/bhs/index.htm

HIPAA Corner… … …

Office for Civil Rights posts two new HIPAA FAQs

Published April 2005

The Office for Civil Rights (OCR) posted on its Web site two new frequently asked questions (FAQ). One discusses requirements regarding sharing protected health information (PHI) with an interpreter; the other covers allowances for responding to a National Medical Support Notice (NMSN).

According to the OCR, healthcare providers do not need patient authorization to disclose PHI to interpreters when the

- Interpreter is part of the provider work force
- Covered entity engages the services of the interpreter as a business associate
- Interpreter is a family member, close friend, or other person designated by the patient as the interpreter for a particular healthcare encounter

In response to the NMSN question, the OCR said the privacy rule permits health plans to provide PHI to state child support enforcement agencies in response to an NMSN. This form constitutes a written request for PHI by a law enforcement agency. Go to *www.hhs.gov/ocr/hipaa* and click on "What's new" for complete information about these FAQs.

HIPAA Security Issues

Q Are the security controls mandated by the HIPAA security rule enough to protect my ePHI?

A The short answer is that security controls are not enough. Someone could maliciously access or destroy electronic protected health information (ePHI) regardless of how many policies and technologies you have in place.

By carrying out the authentication systems, access controls, malware protection, etc. required by HIPAA, you can certainly eliminate the majority of potential attacks, but there's always residual risk.

Many information security managers spend countless hours and money trying to eliminate all threats and vulnerabilities so they won't have to worry about responding to security incidents. This is the wrong approach. Don't try to eliminate all risks but rather ready your organization to respond quickly and efficiently to minimize damage to ePHI when a breach does occur.

Editor's note: Kevin Beaver, CISSP answered this question. This is not legal advice. Consult your facility's legal counsel for questions on legal matters.

Important Information on Corporate Compliance

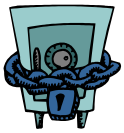
Effects of Exclusion from Participation in Federal Healthcare Programs

No payment will be made by any Federal health care program for any items or services furnished, ordered, or prescribed by an excluded individual or entity. Federal health care programs include Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan). For exclusions implemented prior to August 4, 1997, the exclusion covers the following Federal health care programs: Medicare (Title XVIII), *Medicaid* (Title XIX), Maternal and Child Health Services Block Grant (Title V), Block Grants to States for Social Services (Title XX) and *State Children's Health Insurance* (Title XXI) programs.

No program payment will be made for anything an excluded person furnishes, orders, or prescribes. This payment prohibition applies to the excluded person, *anyone who employs or contracts with the excluded person*, any hospital or other provider where the excluded person provides services, and anyone else the provider may contract with. The exclusion applies regardless of who submits the claims and applies to administrative and management services furnished by the excluded person.

There is a limited exception to exclusions for the provision of certain emergency items or services not provided in a hospital emergency room. See regulations at 42 CFR 1001.1901(c)

User Access Request Forms



The Office of Program Support Services *must* authorize all requests for access to CIS, Office of Human Rights, Office of Grievance and Appeals, Issue Resolution System, and PMMIS (AHCCCS) databases. In order to obtain access to any of these databases, please fax or mail a copy of the appropriate User Access Request Form and User Affirmation Statement to Stacy Mobbs at (602) 364-4736.

For questions or more information, please contact Stacy Mobbs by telephone at (602) 364-4708 or by e-mail at mobbss@azdhs.gov

AHCCCS
Division of Health Care Management
Data Analysis & Research Unit

Encounter File Processing Schedule
June – July 2005

FILE PROCESSING ACTIVITY	June 2005	July 2005
Deadline for Corrected Pended Encounter and New Day File Submission to AHCCCS	Fri 6/3/2005 12:00 PM	Fri 7/8/2005 12:00 PM
Work Days for AHCCCS	7	7
Encounter Pended and Adjudication Files Available to Health Plans.	Tue 6/13/2005	Tue 7/18/2005
Work Days for Health Plans	17	14

NOTE:

1. This schedule is subject to change. If untimely submission of an encounter is caused by an AHCCCS schedule change, a sanction against timeliness error will not be applied.
2. Health Plans are required to correct each pending encounter within 120 days.
3. On deadline days, encounter file(s) must arrive at AHCCCS by 12:00 p.m., Noon, unless otherwise noted

AHCCCS Encounters Error Codes

R410 – Recipient Not Eligible for AHCCCS Services on Service Dates

Review the AHCCCS ID and service begin and end dates for the encounter. The most common error involves the client's termination of enrollment in the health plan. Review the enrollment information for the client using PMMIS screen RP216 – Inquire BHS/FYI Data, this screen indicates current or past enrollments and provides basic data for the client. If you are unable to resolve the issue, please contact the appropriate technical assistant.

P295 – Service Provider Terminated during Service Date Span

Encounters are pending at AHCCCS because the system indicates the billing provider's enrollment status as terminated before the billed dates of service. RBHAs can check provider enrollment status in PMMIS using screen, PR070 – Provider Enrollment Status.

Z805 – Exact Duplicate from Different Health Plans

Encounters are pending because at least one claim was found in the system from another health plan that matches the pended claim. These claims must be researched by both health plans' to determine the cause for the exact duplicate. Each health plan must work together to resolve the issue and decide who should receive payment for the service. Your assigned technical assistant is available to help you with your research.

P295 Service Provider Terminated during Service Date Span	6,036
Z805 Exact Duplicate from Different Health Plans	5,555
R410 Recipient Not Eligible for AHCCCS Services on Service Dates	4,598
Total	16,189

*These errors account for **46.15%** of the pended encounters at AHCCCS.*

Mental Health Problems in Alternative Living Facilities Could be Higher than Expected

Published September 2004

A recent study conducted by the Indiana University School of Medicine found that up to two thirds of Alternative Living Facilities (ALF) residents may have mental health problems, according to the School of Medicine's press release. Researchers interviewed 2100 assisted living residents at 193 facilities in four states. Findings from the study indicated that 22% demonstrated verbal behavioral symptoms, such as humming or repeating questions, 20% exhibited physical behavioral problems, such as wandering, pacing, and restlessness, and 13% had aggressive behavior problems, such as hitting, throwing, and spitting. More than half of the residents that participated in the study took psychotropic medications, according to the release.

Edit Failure Research Requested by RBHAs

In order for the Office of Program Support staff to effectively research encounters failing for any CIS pre-processor errors, the following information is required to expedite resolution to the problem.

- Edit Number
- ICN (minimum of 5)
- Dates of Service
- Provider Id
- Date the file was sent to ADHS/DBHS for processing
- Procedure/Revenue Code

The RBHA should send the request to the appropriate Encounter Representative for research. Your assigned Technical Assistant will report to the RBHA its findings via email, fax, or telephone.

If you need assistance with eligibility, encounters, or coding questions, please contact your assigned Technical Assistant at:

Michael Carter	Excel NARBHA	(602) 364-4710
Eunice Argusta	CPSA-3 CPSA-5 Gila River Navajo Nation Pascua Yaqui	(602) 364-4711
Javier Higuera	PGBHA Value Options	(602) 364-4712

Edit Alerts

An Edit Alert is a faxed and e-mailed notice of system enhancements or changes. The Office of Program Support strives to ensure any system enhancements or changes are communicated to all program participants in an accurate and reliable manner. Edit Alerts will be distributed when the information is first made available and again with the following monthly publication of the Encounter Tidbits.

Correction to Last Month's Edit Number

Alert # 39

Expected implementation July 20, 2005: Encounters will no longer be accepted into CIS for Title 19/21 Clients or services where the Service Provider is listed as an IHS Service Provider unless the service is a Case Management Service (T1016). Case Management encounters will be accepted by CIS.

Encounters for Non-Title 19/21 Clients or services will be accepted into CIS regardless of the IHS flag indication in the Monthly Provider File Record Layout.

Edit Function

Fail pre-processor edit N235-IHS service providers are fee for service only, bill AHCCCS direct.

Examples:

An encounter submitted for a Client who has Behavioral Health Enrollment at AHCCCS on the date of service, and the provider is an IHS Service Provider. The encounter ***will not be accepted*** into CIS unless the service is a Case Management Service (T1016).

An encounter is submitted for a Client who does not have Behavioral Health Enrollment at AHCCCS on the date of service, and the provider is an IHS Servicer Provider: The encounter *will be accepted* into CIS as a subvention encounter.

Coding Q & A … … …

Q May case management be encountered if a provider leaves a note in a client's chart to pass information regarding the client to another provider?

A Leaving a note in the client's chart becomes part of that chart and therefore cannot be billed as Case Management. Page 20, item #1 in the Covered Services Guide General Core Billing Limitations states: *"A provider can only bill for his/her time spent in providing the actual service. For all services, the provider may not bill any time associated with note taking and/or medical record upkeep as this time has been included in the rate."*